Application for

Section 1915(b)(4) Waiver
Fee-for-Service
Selective Contracting Program

Submitted: December XX, 2026

v1.0

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Application for Section 1915(b)(4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Minnesota requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Case Management Waiver (List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
_x_ a renewal request

Section A is:
_x_ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Section B is:
_x_ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5_ years beginning April 1, 2027 and ending March 31, 2032.

State Contact: The State contact person for this waiver is Christina Samion and can be reached by e-mail at christina.samion@state.mn.us. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized Tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

State Response: Notice of the proposal to renew the waiver and a request for comment was sent to Tribal Chairs and Tribal Health Directors on [PLACEHOLDER FOR DATE]. A discussion of the waiver renewal proposal took place at the Tribal Health Director's quarterly meeting on [PLACEHOLDER FOR DATE]. A copy of the consultation letter is provided at Attachment A. [PLACEHOLDER FOR COMMENTS RECEIVED].

A notice requesting public comments on the waiver renewal request was also published in the Minnesota State Register on [PLACEHOLDER FOR DATE] (see Attachment B), and the state used Granicus (an official state government notification system formerly known as GovDelivery) to inform the public about the opportunity to comment on the waiver renewal request (see Attachment C). [PLACEHOLDER FOR COMMENTS RECEIVED].

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

State Response: This selective contracting waiver restricts case management in Minnesota's §1915(c) home and community-based services (HCBS) waivers to county and Tribal human service agencies. Minnesota administers many health and human services programs through its county and Tribal human service agencies. Activities conducted by county and Tribal human service agencies include adult and child protection, provider recruitment, and some licensing activities. In addition, the Minnesota Department of Human Services (Department) has delegated certain administrative activities, with appropriate oversight, to county and Tribal human service agencies, such as Medicaid eligibility and utilization review.

Most importantly for this waiver, state, county and Tribal human service agencies are responsible for §1915(c) waiver eligibility and need determinations, level of care evaluations and reevaluations, and authorization and monitoring of waiver services. County and Tribal human service agencies also have access to state computer systems for waiver activities, including completing assessments, determining eligibility and authorizing services.

Restricting case management in the §1915(c) waivers to county and Tribal human service agencies is a core component of Minnesota's waiver programs because, due to the above mentioned activities, these agencies have existing service infrastructure, knowledge of local resources, proximity to participants and providers to arrange and monitor services, and the ability to provide continuity of care.

Through this selective contracting arrangement with county and Tribal human service agencies, communication is streamlined and duplication minimized for participants because one entity is responsible for all case management activities (i.e., administrative activities and waiver case management services). For example, administrative activities carried out by counties and Tribes such as data entry and service agreements are closely associated with and sometimes inextricably linked to waiver case management services.

The case management waiver was initially approved by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2007 through December 31, 2008, and applied only to case management services covered under the Brain Injury waiver. An amendment, effective July 1, 2007, expanded the waiver authority to case management services covered under all of Minnesota's §1915(c) waiver programs. Since then, the case management waiver has applied to participants whose waiver services are covered fee-for-service and who receive services under one of the following §1915(c) waiver programs:

- Brain Injury (BI), CMS control number 4169
- Community Access for Disability Inclusion (CADI), CMS control number 0166
- Community Alternative Care (CAC), CMS control number 4128
- Developmental Disabilities (DD), CMS control number 0061
- Elderly Waiver (EW), CMS control number 0025

The current case management waiver was approved effective April 1, 2022 and expires on March 31, 2027. The state is requesting a renewal of this waiver effective April 1, 2027 through March 31, 2032.

The following table shows the average monthly persons served by state fiscal year (SFY) in each of the HCBS waiver programs.

Home and Community-Based Services (HCBS) Waivers
Average Monthly Persons Served*

Waiver	SFY 21	SFY 22	SFY 23	SFY 24	SFY 25	SFY 26 (est)
BI	1,078	1,035	990	936	873	836
CAC	638	663	696	718	768	801
CADI	32,349	35,092	37,925	40,973	43,881	47,074
DD	21,727	22,499	23,183	23,822	24,762	25,822
EW	2,508	2,622	2,727	2,857	3,003	3,106
Total	58,300	61,911	65,521	69,306	73,287	77,639

*Includes §1915(c) waiver participants whose waiver services are covered fee-for-service.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

State Response: This selective contracting waiver includes case management services authorized through the following §1915(c) waivers:

- Brain Injury (BI), CMS control number 4169
- Community Access for Disability Inclusion (CADI), CMS control number 0166
- Community Alternative Care (CAC), CMS control number 4128
- Developmental Disabilities (DD), CMS control number 0061
- Elderly Waiver (EW), CMS control number 0025

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _x_ **1915(b)(4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a. ___ **Section 1902(a) (1) - Statewideness**
   b. ___ **Section 1902(a) (10) (B) - Comparability of Services**
   c. _x_ **Section 1902(a) (23) - Freedom of Choice**
   d. ___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   _x_ is different than stipulated in the State Plan (please describe)

   State Response: Case management is an HCBS waiver service that is billed in 15-minute units. The Minnesota State Legislature authorizes rate changes for waiver services. Case management services under the §1915(c) waivers are not paid at the same rate as targeted case management services under the state plan.

2. **Procurement**. The State will select the contractor in the following manner:

   ___ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   _x_ **Other** (please describe)

   State Response: Minnesota has a county-based infrastructure for case management services. State law specifies that county and Tribal human service agencies provide case

management services (see Minnesota Statutes §256B.49, subd. 13; §256S.07, subd. 1; §256B.092, subd. 1a).

All counties and federally recognized Tribes who contract with the Department are enrolled providers and have a Medicaid provider agreement with the Department.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_x_ Beneficiaries will be limited to a single provider in their service area.
___ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

State Response: Waiver participants are limited to using a single provider in their service area, either a county or Tribal human service agency. County and Tribal human service agencies can contract with multiple case management providers and are required under Minnesota Statutes §256B.49, subd. 13, para. (a), clause (3) and §256B.092, subd. 1b, para. (a), clause (5) to provide eligible participants with available options for case management services. Minnesota Statutes §256S.09, subd. 1 allows eligible participants choice among any qualified provider of case management services within the agency. The waiver program operates statewide.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

State Response: Case management is an HCBS waiver service that assists participants in gaining access to waiver and state plan services, as well as medical, social, educational and other necessary services, regardless of the funding source for such services. In accordance with 42 CFR Part 441.301(c), the case manager or case aide shall not have a personal financial interest in the services provided to the participant. Minnesota Statutes §256B.092, subd. 1a, para. (c), §256B.49, subd. 13, para. (c), and §256S.08, subd. 1 prohibit the provision of case management services to a participant by a private agency that has a financial interest in the provision of any other services included in the participant's support plan. Duplicate payments will not be made for case management services to the same participant by more than one provider.

County and Tribal human service agency certified assessors are responsible for completing §1915(c) waiver eligibility and need determinations and level of care evaluations and reevaluations using the MnCHOICES application.

Case managers initiate and oversee the process of reassessment of the participant's level of care, and are responsible for authorization and ongoing monitoring of the provision of

services included in the participant's support plan. Case managers are required to conduct in-person visits with participants a minimum number of times. For the EW program, participants must receive one in-person visit at least once every 12 months. Participants on BI, CAC, CADI and DD must receive a minimum of two in-person visits every 12 months. The participant's annual reevaluation may be counted as one in-person contact when case management activities are performed at the time of the visit.

Case aides shall perform only administrative tasks delegated and supervised by the case manager that do not involve professional expertise or judgment (e.g., case filing, contacts to vendors to schedule services, phone contacts). Case aides shall not conduct participant assessments, reassessments, or service plan development. Case aides must understand, respect and maintain confidentiality in regard to all details of their work.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
_x_ Blind/Disabled Adults and Related Populations
_x_ Blind/Disabled Children and Related Populations
_x_ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children

State Response: This §1915(b)(4) waiver applies only to participants whose §1915(c) waiver services are covered fee-for-service.

This waiver operates concurrently with the following §1915(c) waivers:

- Brain Injury (BI), CMS control number 4169
- Community Access for Disability Inclusion (CADI), CMS control number 0166
- Community Alternative Care (CAC), CMS control number 4128
- Developmental Disabilities (DD), CMS control number 0061
- Elderly Waiver (EW), CMS control number 0025

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program

___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_x_ Other (Please define):

State Response: This waiver does not apply to §1915(c) waiver participants whose waiver services are covered through managed care organizations.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

State Response: The case management service and provider standards are described in Appendix C of the §1915(c) waivers.

1. The Department measures timeliness of beneficiary access to services in the following ways:

   a. Minnesota's Medicaid Management Information System (MMIS)
   The Department monitors access to case management through claims data collected in MMIS. The design of Minnesota's MMIS supports §1915(c) waiver policies and procedures, including those related to case management. All HCBS waiver services, including case management, are authorized in the form of a service agreement that is entered into MMIS. Each service agreement includes the identification number of the participant's case manager.

   b. Lead Agency Reviews
   In accordance with the State's approved §1915(c) waivers, the Department conducts ongoing reviews of the functions delegated to county and Tribal human service agencies. Agencies are randomly selected for review each year, and each is reviewed at least once every four years. The purpose of these reviews is to monitor program compliance, assess delegated administrative functions, evaluate how participant needs are being met, identify best practices and quality improvement opportunities, and determine areas where technical assistance may be beneficial.

The reviews include a randomly selected representative sample of participant case files across Minnesota's §1915(c) waiver programs. When the Department identifies a deficiency in any reviewed activity, it is documented in a final report.

Depending on the level or pattern of non-compliance, the department may issue a request for corrective action. When a corrective action is issued, the county or Tribal human service agency must use a Department-issued template to develop and submit a corrective action plan within 10 business days of the report's issuance. County and Tribal human service agencies must remediate 100% of all identified deficiencies and have 60 days to complete and certify all required corrections.

The final report and corrective action plan (if applicable) are posted publicly on the Department's Lead Agency Review website.

c. HCBS Quality Assurance Plans

County and Tribal human service agencies submit a Quality Assurance (QA) plan to the Department for the HCBS waivers as part of preparation for the lead agency review. The QA plan is a self-assessment and self-monitoring tool. Many of the questions in the self-assessment correlate to activities that are assessed during the lead agency reviews.

The QA plan parallels the structure of CMS's quality assurance matrix and includes self-assessment questions concerning operational and administrative activities. If the self-assessment is not fully compliant, the county or Tribal human service agency must submit a remediation plan. The Department reviews the remediation plan and discusses with the county or Tribal human service agency any areas of concern as part of the technical assistance delivered during the review. The Department also uses the information provided in the QA plans to identify possible regional or statewide trends.

2. The Department provides the following remediation in the event waiver participants are unable to access services in a timely fashion:

Remediation and Corrective Action Plans

One way Department staff assess compliance with timeliness is through required in-person contact standards. Case managers are required to conduct in-person visits with participants a minimum number of times. For the EW program, participants must receive one in-person visit at least once every 12 months. Participants on BI, CAC, CADI and DD must receive a minimum of two in-person visits every 12 months. The participant's annual reevaluation may be counted as one in-person contact when case management activities are performed at the time of the visit.

Department staff review a sample of participant case files during each lead agency review. County and Tribal human service agencies that do not have documentation demonstrating the required number of in-person visits are identified as not meeting the standard. Information from the case file reviews is maintained in a database. This

measure reflects only documented in-person contacts; phone calls, other collateral contacts, or undocumented visits are not included. When any file in the review sample does not meet in-person contact requirements, the county or Tribal human service agency must remediate the deficiency by completing the required visit(s) for those participants within 60 days of the review.

If a county or Tribal human service agency is found to have a pattern of non-compliance with in-person visit requirements, the Department issues a corrective action in the final report. The county or Tribal human service agency must use a Department-issued template to develop and submit a corrective action plan within 10 business days of the final report being issued. Both the final report and corrective action plan are published publicly. The corrective action plan must outline the steps the county or Tribal human service agency will take to strengthen its practices and ensure case managers complete all required visits going forward. Common corrective strategies include providing additional training, adjusting case load sizes, and establishing systems to monitor visit completion.

The Department has not encountered difficulties obtaining corrective action plans from county and Tribal human service agencies or ensuring remediation of issues. Department staff maintain regular communication with county and Tribal human services representatives to ensure requirements are met within the timelines. As of April 2026, the compliance rate for submitting corrective action plans and completing required case file remediation was 100%. If a case closes within 60 days of the review (e.g., due to a change in county of financial responsibility or the participant's death), remediation by the county or Tribal human service agency is not required.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

State Response:

1. State law requires that all 87 counties provide case management services to §1915(c) waiver participants. To manage staff capacity and workload issues, counties and Tribal

human service agencies may sub-contract with qualified private vendors for case management services. State law also allows federally recognized Tribes to contract with the Department to provide case management services. Members of Tribes that contract with the Department may choose to receive case management through their Tribe or the county. Currently, three Tribes provide case management services under contract with the state: Miskwaagamiiwi-Zaagaiganing (Red Lake Nation), Gaa-waabaabiganikaag (White Earth), and Gaa-zagaskwaajimekaag (Leech Lake Band of Ojibwe).

2. The Department monitors the number of participants receiving case management through MMIS data. In addition, the Department uses the lead agency review process, as described in the state's response to Part II, Item A, to monitor and evaluate access to case management, compliance with program requirements, and the quality of the service received, including county and Tribal human service agency use of person-centered practices. Case management services and provider standards are described in Appendix C of the §1915(c) waivers and are based on Minnesota Statutes §256B.49, subd. 13; §256S; and §256B.092, subd. 1a.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

State Response: The Department monitors utilization of case management services through MMIS. County and Tribal human service agencies enter level of care and financial eligibility information into MMIS. Editing logic is then applied before an applicant is determined and approved eligible for an HCBS waiver. Once eligibility is approved in MMIS, the participant's service authorization is entered in MMIS, including case management services. The amount of case management included in a support plan is determined based on the participant's assessed needs and level of involvement the participant chooses the case manager to have in their support plan implementation. MMIS has multiple data interfaces to validate participant information including data from provider enrollment, service categories, rate tables, and individual case mix budget amounts. The authorization must be present and approved in MMIS before a claim can be paid. Claims editing assures that claims paid match prior authorizations.

The Department uses MMIS claims data to measure the units of case management provided and determine the average amount of case management received annually per participant. The data includes participants who are covered fee-for-service in Minnesota's §1915(c) waivers. The Department reviews utilization over a 12-month period because utilization of

case management by participants varies from month to month. Some participants elect to receive services through the consumer-directed community supports (CDCS) benefit, which is Minnesota's self-direction service option. Participants using CDCS may receive supports akin to case management from entities that are not county or Tribal human service agencies. These supports may include assistance in developing a support plan, arranging for or scheduling services, or other case management related activities. For participants who elect CDCS, we include the amount of case management provided by county and Tribal human service agencies.

The data shows that on average 21.89 hours of case management were claimed per participant, per year in fiscal year 2024. In addition, on average 22.33 hours of case management were claimed per participant, per year in fiscal year 2025. The table below shows the averages separately by waiver.*

	BI	CADI	DD	EW	CAC	TOTAL
Average number of hours for FY 2024	27.50	24.52	24.44	10.75	22.25	21.89
Number of participants for FY 2024	998	47,743	25,274	6,731	838	81,584
Average number of hours for FY 2025	28.18	24.76	24.95	10.27	23.49	22.33
Number of participants for FY 2025	941	50,728	26,357	7,324	881	86,231

*Includes §1915(c) waiver participants whose waiver services are covered fee-for-service.

Remediation activities:

1. Fair Hearings
   Annually and when there is an increase, decrease, suspension or termination of services, HCBS waiver participants receive information about their right to a fair hearing and instructions for requesting a hearing. The Department's Appeals Division maintains data regarding appeals in a central database.

   The Department monitors fair hearing requests to identify patterns or trends that may indicate problems or concerns with the administration and management of the §1915(c) waivers. Department policy staff contact the county or Tribal human service agency if there are concerns about an individual appeal issue that does not appear to be consistent with policies or procedures. When possible, these contacts are made in advance of the hearing to resolve the issue before the hearing.

2. Lead Agency Reviews
   In Part II, Item A, we described the lead agency reviews. Compliance with many requirements is monitored during the review and the information is maintained in a database. Corrective actions are issued if the county or Tribe being reviewed is found to have a pattern of non-compliance with waiver policies and procedures. The county or

Tribe is then required to submit a corrective action plan using a Department-issued template.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

State Response: In Part II, Item C, we noted that the Department monitors participant access to waiver services through lead agency reviews, MMIS data, and fair hearings. Further review and analysis of compliance with quality standards occurs through the following:

1) Lead Agency Reviews

Data collected
During a lead agency review, Department staff review a sample of participant files to evaluate compliance with in-person contact requirements. Counties or Tribes that do not have documentation of an in-person visit are identified as not meeting the required standard. Information from case file reviews is maintained in a centralized database. The Department uses case manager in-person contact as a measure to monitor access to case management. Results are based on an unduplicated number of participants. This measure includes only documented in-person contacts; phone calls, other collateral contacts, or undocumented visits are not counted. Please refer to Part II, Item A (Timely Access Standards) for a more detailed description of the corrective action plan process.

The Department has been conducting reviews of Minnesota's 87 counties and three Tribal human service agencies that administer HCBS waiver programs since 2006. Lead agency

reviews are continuous and ongoing. They occur approximately once every four years per agency. If a corrective action has been issued based on the findings from a review, the county or Tribe is responsible for using a Department-issued template to develop and implement a corrective action plan and ensure the plan results in compliant practices.

All county and Tribal human service agencies are asked to report the status of any corrective action plans within 18 months of their review. At that time, the Department sends a follow-up survey requesting information on several metrics, including the current status of the corrective action plan. The Department asks whether the county or Tribal human service agency is now in compliance with the issues identified during the review and what strategies it uses for ongoing monitoring. If the county or Tribal human service agency has not demonstrated sufficient progress, the Department requires submission of an updated corrective action plan and may refer the county or Tribal human service agency to internal Department program areas for technical assistance, as needed. The Department formally reviews compliance with the corrective action plan during the next review.

The Department follows up and closely monitors county and Tribal human service agencies whose programs do not meet the CMS quality compliance standard (i.e., at or below 85% compliance). If a county or Tribal human service agency receives five or more repeat corrective actions from the prior review cycle and/or is unable to bring identified performance issues into compliance over several years, the Department conducts a condensed review of case files one year after the formal review.

Please also refer to Attachment D for a copy of Appendix H: Quality Improvement Strategy for the §1915(c) waivers.

Analysis

Below is data collected from the lead agency reviews from April 2019 through April 2026.

Round IV: From April 2019 to August 2023, all 87 county and Tribal human service agencies that administer HCBS waiver programs were reviewed. The summary results indicate that 99% of participants included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. The Department conducted followed up with every county and Tribal human service agency that had cases out of compliance at the time of review, and 100% of all those cases were subsequently brought to compliance.

Round V: The Department is nearing the midpoint of Round V reviews of county and Tribal human service agencies. Between May 2024 and April of 2026, 43 county and Tribal human service agencies were reviewed. The summary results indicate that 94% of participants included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. The Department conducted followed up with every county and Tribal human service agency that had cases out of compliance at the time of review, and 100% of all those cases were subsequently brought to compliance.

System Improvements

The Data, Policy and Quality Assurance workgroup within the Aging and Adult Services Division is responsible for reviewing the quality improvement strategy and coordinating with other areas of the agency that have similar strategies. The group analyzes data regarding performance measures and identifies remediation processes as needed. Issues requiring intervention beyond existing remediation processes (i.e., system improvements outlined below) are directed to the Aging and Adult Services Division policy team. The policy team completes additional analysis and, if indicated, develops new or revises policies and procedures. The policy team responsible for this work within the Aging and Adult Services Division meets monthly when issues are identified.

CMS's current quality assurance benchmark sets a compliance threshold of 86% for the state's quality performance measures. The Department reports data to CMS annually on compliance with the quality performance measures.

The lead agency review uses the same threshold (86%) for compliance when reviewing county and Tribal human service agencies. Across the 20 technical compliance items reviewed during the lead agency review, one item fell below the 86% compliance benchmark after statewide aggregation of the data for the five HCBS programs in Round V. The item below the benchmark was timeliness between assessment and support plan.

Timeliness between assessment and support plan

The criteria for this item was refined during Round IV to evaluate the timeliness between assessment and support plan. Overall, 23% of all case files sampled between May 2024 and April 2026 did not meet the timeline requirements. The following is an example of the corrective action issued to each county or Tribal human service agency that was found to be out of compliance with this item: *Per Minnesota Statutes §256B.0911, subd. 29(a), the certified assessor and the individual responsible for developing the support plan must complete the assessment summary and support plan no more than 60 calendar days after the assessment visit. Overall XX percent of case files reviewed were not compliant with the required timeline between assessment and support plan.*

Additional Improvements

The Department has seen significant improvements in the areas identified during the previous reporting period (April 2019 to June 2021):

- ICF/DD Related Conditions Checklist: 88.9% compliant (up from 76%)
- Timeliness between assessment and support plan: 77% compliant (up from 69%)
- Needs identified in the assessment are documented in the support plan: 97% compliant (up from 78%)

2) Fair Hearings

Data collected

The Department's Appeals Division maintains a database of fair hearing requests filed by waiver participants. The database captures information that includes the date of filing, appeal issue, all subsequent actions and dates of action, and the final disposition of the

appeal. The Department's Aging and Adult Services Division staff review fair hearing requests when resolving individual issues and tracking waiver appeal patterns and trends involving the §1915(c) waivers.

Analysis
Review and analysis of waiver appeals data indicates there were two fair hearing requests filed that identified a case management issue, one of which was dismissed and the other was affirmed.

3) Audits of enrolled service providers

Data Collected
All county and Tribal human service agencies have a Medicaid provider agreement with the Department and are enrolled as providers of case management services, and are required to revalidate their enrollment record every three to five years with the Department's Provider Eligibility and Compliance (PEC) Division. PEC also conducts monthly internal audits to assess compliance with provider screening and enrollment regulations and operational procedures. Twenty percent (20%) of HCBS waiver and demonstration service provider enrollment actions are randomly selected for audit and reviewed each month. All unresolved issues discovered through the audits are resolved by provider enrollment specialists.

Analysis
Analysis of audit reviews indicate there were no unresolved issues identified for case management services provided by county or Tribal human service agencies.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

State Response: Minnesota administers many health and human services programs through county and Tribal human service agencies. This includes established infrastructures for such things as adult and child protection, as well as provider recruitment and some licensing activities. County and Tribal human service agencies have delegated responsibilities for certain administrative activities such as Medicaid eligibility and utilization review. County and Tribal human service agencies also have access to state computer systems for purposes of determining eligibility and authorizing waiver services.

County and Tribal human service agencies are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services. Counties and Tribes are also expected to manage spending for waiver services.

Restricting case management in the §1915(c) waiver to county and Tribal human service agencies utilizes the existing service infrastructure, knowledge of local resources, proximity to participants and providers to arrange and monitor services, and the continuity of one entity being responsible for all aspects of case management (i.e., administrative activities and waiver case management services).

Administrative activities carried out by counties and Tribes are closely associated with and sometimes inextricably linked to waiver case management services. Dividing these functions between counties or Tribes and an unlimited number of non-county/Tribal providers under our current case management structure would cause duplication and increase costs to the program.

As provided in Part II, Item C, the Department monitors participants' access to waiver services through lead agency review data, MMIS claims, and fair hearings.

1) Lead Agency Reviews. Reviews have been conducted in all 87 counties and three Tribal human service agencies that administered HCBS waiver programs from 2006 to 2026. The lead agency reviews occur approximately once every four years with the fifth round of waiver reviews currently underway.

2) Fair Hearings. When a fair hearing involves an HCBS waiver, the Appeals Division forwards the request to the applicable policy division. Staff from the waiver policy divisions review fair hearing requests concerning HCBS waivers to monitor trends and patterns, and identify issues that may require follow-up. The Disability Services Division reviews fair hearings related to the BI, CAC, CADI and DD waivers. The Aging and Adult Services Division reviews fair hearings related to the Elderly Waiver.

3) MMIS and MnCHOICES. The Department generates several reports using MMIS data such as encumbrance and payment reports that are used to monitor authorization patterns. The reports are available to county and tribal human service agencies as well as Department staff. MMIS and MnCHOICES application information is used for a variety of quality assessment and program improvement purposes. The Department monitors MnCHOICES data to see whether timeframes for assessments and support plans are met, participants are offered a choice between services and providers, and signatures showing participant and case manager agreement with service plans are obtained among other things. Reports are generated monthly and ad hoc reports are used to research and analyze issues as needed. These reports support county and tribal human service agencies with continuous quality improvement activities and policy compliance monitoring.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

State Response: Participants are informed of what choices they have among case managers at the time of enrollment.

The Department's website at Federal Health Care Waivers provides the public with information about Medicaid waivers in Minnesota, including the case management §1915(b)(4) waiver. The website is updated on a regular basis and includes information about new waiver requests, proposed renewals, and public comment periods. The page includes links to copies of waiver applications and approval documents.

The Department made efforts to ensure that participants were aware of and had the opportunity to comment on this waiver renewal request. A notice requesting public comments on the waiver renewal request was published in the Minnesota State Register and the state used Granicus (an official state government notification system formerly known as GovDelivery) to inform the public about the opportunity to comment on the waiver renewal request.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

State Response: This waiver operates concurrently with the §1915(c) waivers listed in Part I, Item D.

Participants who are enrolled in these waiver programs all meet an institutional level of care. A requirement of the waivers is that an individual, person-centered support plan be developed for each participant. The support plan lists the services necessary to meet the participant's individualized assessed needs, and that directly benefit and support the participant in community-based living.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

State Response: Minnesota administers many health and human services programs through its county and Tribal human service agencies. This includes established infrastructures for such things as adult and child protection, as well as provider recruitment and some licensing activities. County and Tribal human service agencies have delegated responsibilities for certain administrative activities such as Medicaid eligibility and utilization review. County and Tribal human service agencies also have access to state computer systems for purposes of determining eligibility and authorizing waiver services.

County and Tribal human service agencies are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services.

Restricting case management in the §1915(c) waivers to county and Tribal human service agencies is a primary component of Minnesota's waiver programs. Counties and Tribes have existing service infrastructure and knowledge of local resources, and their proximity to participants and providers allows them to arrange and monitor services and provide continuity in all aspects of case management (i.e., administrative activities and waiver case management services).

Through the use of county and Tribal human service agencies for the provision of case management, communication is streamlined and duplication is minimized. Administrative activities carried out by counties and Tribes are closely associated with and sometimes inextricably linked to waiver case management services.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 4/1/2027 to 3/31/2028

Trend rate from current expenditures (or historical figures): 2.92%

Projected pre-waiver cost	_____	
Projected Waiver cost	_____	$257,580,963
Difference:	_____	

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment E for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated based on both the Medical Assistance service total expenditures and on the actual caseload per member, per month (PMPM) projections for the five-year period. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost effectiveness projections.

P1 Aggregate PMPM $238.26

P1 PMPM-Projected Waiver Costs by MEG

BI	272.47
CADI	249.03
DD	226.35
CAC	233.59
EW	154.18

Year 2 from: 4/1/2028 to 3/31/2029

Trend rate from current expenditures (or historical figures): 2.92%

Projected pre-waiver cost	_____	
Projected Waiver cost	_____	$282,873,590
Difference:	_____	

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment E for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated based on both the Medical Assistance service total expenditures and on the actual caseload per member, per month (PMPM) projections for the five-year period. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost effectiveness projections.

P2 Aggregate PMPM $245.26

P2 PMPM-Projected Waiver Costs by MEG

BI	280.10
CADI	256.00
DD	232.68
CAC	240.13
EW	158.50

Year 3 (if applicable) from: 4/1/2029 to 3/31/2030
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 2.92%

Projected pre-waiver cost	_____	
Projected Waiver cost	_____	$310,363,362
Difference:	_____	

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment E for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P3 Aggregate PMPM $252.10

P3 PMPM-Projected Waiver Costs by MEG
BI 287.52
CADI 262.79
DD 238.85
CAC 246.50
EW 162.70

Year 4 (if applicable) from: 4/1/2030 to 3/31/2031
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 2.92%

Projected pre-waiver cost _____
Projected Waiver cost _____ $340,936,450
Difference: _____

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment E for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P4 Aggregate PMPM $259.30

P4 PMPM-Projected Waiver Costs by MEG
BI 295.34
CADI 269.94
DD 245.35
CAC 253.20
EW 167.12

Year 5 (if applicable) from: 4/1/2031 to 3/31/2032
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 2.92%

Projected pre-waiver cost _____
Projected Waiver cost _____ $374,933,388
Difference: _____

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment E for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P5 Aggregate PMPM $266.86

P5 PMPM-Projected Waiver Costs by MEG

BI	303.55
CADI	277.44
DD	252.17
CAC	260.24
EW	171.77

Attachment A

Placeholder for Tribal Consultation Letter

Attachment B

Placeholder for State Register Notice

Attachment C

Placeholder for Granicus (formerly GovDelivery) Notice

Appendix H: Quality Improvement Strategies for the §1915(c) Waivers

Waiver Name	Waiver Number
Brain Injury (BI)	MN.4169.R07.00
Community Access for Disability Inclusion (CADI)	MN.0166.R08.01
Community Alternative Care (CAC)	MN.4128.R08.04
Developmental Disabilities (DD)	MN.0061.R08.05
Elderly Waiver (EW)	MN.0025.R09.04

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process
The DHS Quality Essentials Team (QET) will review and analyze performance and remediation data ("monitoring data") according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
Performance Measure and Remediation (monitoring) data

Analysis (QET)
1. Is there a problem (single instance or trend) indicated by the monitoring data?
   If yes, test data (step 2).
   If no, return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
   If yes, Identify what type of problem is indicated (i.e., policy, process, and/or "bad actor").
   If no, return to monitoring.
3. Do existing remediation processes address the identified problem?
   If yes remediate and return to monitoring.
   If no enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (policy team & QET)
Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
   If yes, develop data driven policy alternatives.
   If no, develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select "best" policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes, develop data driven internal process alternatives.
   If no, develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes, develop data driven external process alternatives.
   If no, develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select "best" process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.
High-level monitoring and trending data will be communicated to community partners and the public via:
- annually providing information to the Department of Human Services Aging and Disability Services Administration quality management-related community partner bodies; and
- mandated legislative reports.

Regarding the rate management system (RMS) implemented on 1/1/2014, the state monitors and conducts fiscal analysis to ensure the RMS is used correctly. Fiscal impacts of the system are analyzed at the regional, county or Tribal human services organization, provider and service levels. This analysis investigates differences between historical rates, banded rates and framework rates to detect trends, identify and correct errors, and evaluate the effectiveness of system improvements.

Additionally, the system is monitored through review and comparison of RMS and MMIS data to ensure county or Tribal human services organizations are utilizing RMS to determine appropriate rates, and that those rates are correctly entered in MMIS.

Full system evaluation reports were provided to the legislature on the following schedule:
•January 15, 2021

A report will be provided to the legislature once every four years thereafter.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the Department of Human Services Disability Services Division leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ● **Other** *(Please provide a description of the survey tool used):*

We conduct the NCI and NCI-AD surveys annually.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process
The DHS Quality Essentials Team (QET) will review and analyze performance and remediation data (monitoring data) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
Performance Measure and Remediation (monitoring) data

Analysis (QET)
1. Is there a problem (single instance or trend) indicated by the monitoring data?
   If yes test data (step 2).
   If no return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
   If yes Identify what type of problem is indicated (i.e., policy, process, and/or bad actor).
   If no return to monitoring.
3. Do existing remediation processes address the identified problem?
   If yes remediate and return to monitoring.
   If no enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (policy team & QET)
Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
   If yes develop data driven policy alternatives.
   If no develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select "best" policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes develop data driven internal process alternatives.
   If no develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes develop data driven external process alternatives.
   If no develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select best process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:
- a web-based performance measure dashboard;
- annually providing information to DHS Aging and Disability Services Administration quality management-related stakeholder bodies; and
- mandated legislative reports.

Regarding the rate management system (RMS) implemented on 1/1/2014, the state monitors and conducts fiscal analysis to ensure the rates management system is used correctly. Fiscal impacts of the system are analyzed at the regional, county or Tribal human services organization, provider and service levels. This analysis investigates differences between historical rates, banded rates and framework rates to detect trends, identify and correct errors, and evaluate the effectiveness of system improvements.

Additionally, the system is monitored through review and comparison of RMS and MMIS data to ensure county or Tribal human services organizations are utilizing RMS to determine appropriate rates, and that those rates are correctly entered in MMIS.

Full system evaluation reports were provided to the legislature on the following schedule:

•January 15, 2021

A report will be provided to the legislature once every four years thereafter.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS Disability Services Division leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ● **Other** *(Please provide a description of the survey tool used):*

We conduct the NCI and NCI-AD surveys annually.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process
The DHS Quality Essentials Team (QET) will review and analyze performance and remediation data (monitoring data) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
Performance Measure and Remediation (monitoring) data

Analysis (QET)
1. Is there a problem (single instance or trend) indicated by the monitoring data?
    If yes - test data (step 2).
    If no - return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
    If yes - Identify what type of problem is indicated (i.e., policy, process, and/or "bad actor").
    If no - return to monitoring.
3. Do existing remediation processes address the identified problem?
    If yes - remediate and return to monitoring.
    If no - enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (policy team & QET)
Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
    If yes - develop data driven policy alternatives.
    If no - develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select best policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
    If yes - develop data driven internal process alternatives.
    If no - develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
    If yes - develop data driven external process alternatives.
    If no - develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select best process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:
• a web-based performance measure dashboard;
• annually providing information to DHS Aging and Disability Services Administration quality management-related stakeholder bodies; and
• mandated legislative reports.

Regarding the rate management system (RMS) implemented on 1/1/2014, the state will monitor and conduct fiscal analysis to ensure the RMS is used correctly. Fiscal impact of the system will be analyzed at the regional, county or tribal human services organization, provider and service levels. This analysis will investigate differences between historical rates, banded rates and framework rates to detect trends, identify and correct errors, and evaluate the effectiveness of system improvements.

Additionally, the system will be monitored through review and comparison of RMS and MMIS data to ensure county or tribal human services organizations are utilizing RMS to determine appropriate rates, and that those rates are correctly entered in MMIS.

Full system evaluation reports were be provided to the legislature on the following schedule:
•January 15, 2021

A report will be provided to the legislature once every four years thereafter.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS Disability Services Division leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ● **Other** *(Please provide a description of the survey tool used):*

We conduct the NCI and NCI-AD surveys annually.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process
The DHS Quality Essentials Team (QET) will review and analyze performance and remediation data (monitoring data) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
Performance Measure and Remediation (monitoring) data

Analysis (QET)
1. Is there a problem (single instance or trend) indicated by the monitoring data?
    If yes, test data (step 2).
    If no, return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
    If yes, Identify what type of problem is indicated (i.e., policy, process, and/or "bad actor").
    If no, return to monitoring.
3. Do existing remediation processes address the identified problem?
    If yes, remediate and return to monitoring.
    If no, enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (policy team & QET)
Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
    If yes, develop data driven policy alternatives.
    If no, develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select best policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
    If yes, develop data driven internal process alternatives.
    If no, develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
    If yes, develop data driven external process alternatives.
    If no, develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select best process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:
• a web-based performance measure dashboard;
• annually providing information to DHS-CSA quality management-related stakeholder bodies; and
• mandated legislative reports.

Regarding the rate management system implemented on 1/1/2014, the state will monitor and conduct fiscal analysis to ensure the rates management system is used correctly. Fiscal impact of the system will be analyzed at the regional, county or tribal human services organization, provider and service levels. This analysis will investigate differences between historical rates and framework rates to detect trends, identify and correct errors, and evaluate the effectiveness of system improvements.

Additionally, the system will be monitored through review and comparison of rate management system (RMS) and MMIS data to ensure county or tribal human services organizations are utilizing RMS to determine appropriate rates, and that those rates are correctly entered in MMIS.

Full system evaluation reports will be provided to the legislature on the following schedule:
• January 15, 2021

A report will be provided to the legislature once every four years thereafter.
Beginning in 2012 and every two years thereafter, the state has conducted a Gaps Analysis on the current capacity and gaps in long-term care services and supports.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS Disability Services Division leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ● **Other** *(Please provide a description of the survey tool used):*

We conduct the NCI and NCI-AD surveys annually.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process:
The DHS Quality Essentials Team (QET) will review and analyze collected performance measure and remediation data ("monitoring data") according to the following process outlined below. The QET is a team made up of program and policy staff from all waiver programs.

Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

The QET has identified and implemented a waiver quality monitoring and improvement process for identifying the level of remediation and any systems improvements required as indicated by performance monitoring.

- Input (all identified data sources): Performance Measure and Remediation (monitoring) data
- Analysis (QET)

1. Is there a problem (single instance or trend) indicated by the monitoring data?
   If yes - test data (step 2).
   If no - return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
   If yes - Identify what type of problem is indicated (i.e., policy, process, and/or "bad actor").
   If no - return to monitoring.
3. Do existing remediation processes address the identified problem?
   If yes - remediate and return to monitoring.
   If no - enter appropriate system improvement realm (i.e., policy or process analysis).

- System Improvement (policy team & QET)

A. Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
   If yes - develop data driven policy alternatives.
   If no - develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select "best" policy alternative.
4. Enact new policy and return to monitoring.

B. Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes - develop data driven internal process alternatives.
   If no - develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes - develop data driven external process alternatives.
   If no - develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select "best" process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other**	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Specify:	Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:

- a web-based performance measure dashboard developed by Department located at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/public-planning-performance-reporting/performance-reports/#
- annually providing information to DHS-ADSA quality management-related stakeholder bodies; and
- mandated legislative reports.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS-ADSA leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

DHS periodically conducts studies of current capacity and gaps in long-term care services and supports. The results of these studies are used to identify short as well as long-term strategies for expanding and ensuring provider capacity and choice.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**

Other *(Please provide a description of the survey tool used):*

	CAC			CADI			BI			DD		
Case Mgmt WY	Waiv Enro Mo	Expenditures	PMPM	Waiv Enro Mo	Expenditures	PMPM	Waiv Enro Mo	Expenditures	PMPM	Waiv Enro Mo	Expenditures	PMPM
Actual												
4/1/11-3/31/12	4,205	792,818	188.54	202,414	30,727,700	151.81	16,276	3,080,800	189.28	185,575	26,734,073	144.06
4/1/12-3/31/13	4,432	831,070	187.52	202,946	30,418,122	149.88	16,245	3,259,869	200.67	188,189	26,687,476	141.81
4/1/13-3/31/14	4,500	741,027	164.67	212,089	31,701,204	149.47	16,301	3,313,282	203.26	190,992	27,251,242	142.68
4/1/14-3/31/15	4,600	813,401	176.83	220,861	36,663,065	166.00	16,270	3,618,369	222.40	193,185	29,752,005	154.01
4/1/15-3/31/16	4,909	889,571	181.21	238,492	42,370,258	177.66	15,948	3,807,853	238.77	198,704	31,941,190	160.75
4/1/16-3/31/17	5,502	1,130,078	205.39	270,653	49,634,664	183.39	15,204	3,728,701	245.24	208,090	34,269,334	164.69
4/1/17-3/31/18	6,194	1,244,284	200.89	300,734	58,052,278	193.04	14,549	3,639,195	250.13	221,564	39,276,029	177.27
4/1/18-3/31/19	6,776	1,360,507	200.78	325,473	66,634,268	204.73	14,004	3,571,063	255.00	235,925	45,882,640	194.48
4/1/19-3/31/20	7,433	1,539,322	207.09	354,740	74,680,898	210.52	13,464	3,494,432	259.54	249,992	49,068,616	196.28
4/1/20-3/31/21	7,829	1,672,273	213.60	390,548	85,744,025	219.55	13,174	3,169,511	240.59	262,073	51,185,498	195.31
4/1/21-3/31/22	8,284	1,726,647	208.43	427,777	90,805,697	212.27	12,737	3,038,161	238.53	271,347	52,146,322	192.18
4/1/22-3/31/23	8,603	1,791,459	208.24	463,230	98,736,806	213.15	12,223	2,816,210	230.40	279,994	52,942,553	189.08
4/1/23-3/31/24	8,975	1,819,976	202.78	500,122	111,501,273	222.95	11,578	2,707,887	233.88	287,515	57,293,669	199.27
4/1/24-3/31/25	9,480	2,015,203	212.57	535,225	121,294,125	226.62	10,753	2,666,233	247.95	297,067	61,189,423	205.98
Projected												
4/1/25-3/31/26	9,953	2,189,929	220.04	581,114	136,316,153	234.58	10,753	2,759,818	256.66	307,496	65,560,812	213.21
4/1/26-3/31/27	10,449	2,370,837	226.90	630,938	152,621,413	241.90	10,753	2,845,925	264.66	318,292	69,979,831	219.86
4/1/27-3/31/28	10,970	2,562,459	233.59	685,034	170,595,302	249.03	10,753	2,929,879	272.47	329,467	74,573,564	226.35
4/1/28-3/31/29	11,517	2,765,533	240.13	743,768	190,408,104	256.00	10,753	3,011,916	280.10	341,034	79,353,060	232.68
4/1/29-3/31/30	12,091	2,980,346	246.50	807,537	212,211,848	262.79	10,753	3,091,732	287.52	353,007	84,315,669	238.85
4/1/30-3/31/31	12,693	3,214,035	253.20	876,774	236,673,637	269.94	10,753	3,175,827	295.34	365,400	89,649,725	245.35
4/1/31-3/31/32	13,326	3,468,071	260.24	951,948	264,109,330	277.44	10,753	3,264,115	303.55	378,228	95,376,907	252.17

WY25 data is the last year of actual enrollment and PMPM. WY26 data is incomplete at this time.
Enrollment is projected using the most recent five year trend in the data (WY25 over WY20).
PMPMs are projected using the CMS Medicare Economic Index (2026 Q1 projections)
Trends in the aggregate projections differ from the five-year aggregate trends because of case-mix changes.

Five-Year Enrollment Trends	**Enrollee Months**	**Enrollee Months**	**Enrollee Months**	**Enrollee Months**
WY 25 over WY 20	4.99%	8.57%	-4.40%	3.51%

Trends in Projections	**Enrollee Months**	**PMPM**	**Enrollee Months**	**PMPM**	**Enrollee Months**	**PMPM**	**Enrollee Months**	**PMPM**
WY 32 over WY 27	4.99%	2.78%	8.57%	2.78%	0.00%	2.78%	3.51%	2.78%

Note: BI months set to 0 trend, rather than negative.

Case Mgmt WY	EW FFS Waiv Enro Mo	EW FFS Expenditures	EW FFS PMPM		Aggregate Total Waiv Enro Mo's	Aggregate Total Expenditures	Aggregate PMPM		PMPM Targets		CMS MEI annual increase* 2026 Q1 projections
Actual											
4/1/11-3/31/12	29,204	3,733,405	127.84		437,674	65,068,795	148.67				
4/1/12-3/31/13	30,899	3,823,454	123.74		442,711	65,019,990	146.87				
4/1/13-3/31/14	30,685	3,655,444	119.13	R1	454,567	66,662,199	146.65				
4/1/14-3/31/15	29,390	3,882,786	132.11	R2	464,306	74,729,626	160.95				
4/1/15-3/31/16	31,771	4,308,757	135.62	R3	489,824	83,317,628	170.10				
4/1/16-3/31/17	32,452	4,645,528	143.15	I	531,901	93,408,305	175.61				
4/1/17-3/31/18	33,498	5,081,150	151.69		576,539	107,292,936	186.10				
4/1/18-3/31/19	34,026	5,405,342	158.86		616,204	122,853,820	199.37				
4/1/19-3/31/20	35,119	5,569,236	158.58		660,748	134,352,503	203.33				
4/1/20-3/31/21	33,503	5,669,474	169.22		707,127	147,440,782	208.51				
4/1/21-3/31/22	34,639	5,475,622	158.08		754,784	153,192,449	202.96			Old	
4/1/22-3/31/23	35,982	5,366,907	149.16		800,032	161,653,935	202.06		226.75	P1	
4/1/23-3/31/24	37,814	5,652,762	149.49		846,004	178,975,567	211.55		236.53	P2	
4/1/24-3/31/25	40,937	5,743,743	140.31		893,462	192,908,728	215.91		246.75	P3	
Projected											
4/1/25-3/31/26	42,212	6,130,446	145.23		951,528	212,957,158	223.81		257.45	P4	3.51%
4/1/26-3/31/27	43,526	6,518,531	149.76		1,013,958	234,336,538	231.11	New	268.64	P5	3.12%
4/1/27-3/31/28	44,881	6,919,757	154.18		1,081,104	257,580,963	238.26	P1			2.95%
4/1/28-3/31/29	46,278	7,334,977	158.50		1,153,349	282,873,590	245.26	P2			2.80%
4/1/29-3/31/30	47,719	7,763,767	162.70		1,231,106	310,363,362	252.10	P3			2.65%
4/1/30-3/31/31	49,204	8,223,227	167.12		1,314,825	340,936,450	259.30	P4			2.72%
4/1/31-3/31/32	50,736	8,714,965	171.77		1,404,992	374,933,388	266.86	P5			2.78%

*increase from midpoint of previous WY to midpoint ot current WY

Five-Year Enrollment Trends	Enrollee Months	Enrollee Months
WY 25 over WY 20	3.11%	6.22%

	Aggregate Trend in Projections	
Trends in Projections	**Enrollee Months**	**Enrollee Months**
WY 32 over WY 27	3.11%	6.74%

	PMPM	PMPM
WY 32 over WY 27	2.78%	2.92%